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Leicestershire Partnership NHS Trust

Public Trust Board – 26 July 2022

Infection Prevention and Control Six-Monthly Report to Trust Board

Introduction

This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive Infection Prevention and Control (IPC) strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

Background

The IPC team currently has 3.7 Whole Time Equivalent (WTE) Infection Prevention and Control Nurses and 1 WTE IPC administrator. The team is supported and managed by the Interim Deputy Director of Nursing and Quality/Deputy Director of Infection Prevention and Control (DDIPaC). Recruitment into the IPC team for vacancies due to retirement has proved challenging due to the specialist skills and knowledge required and national recruitment to enhance IPC teams throughout the pandemic. The team are looking at new ways to attract and develop secondment opportunities to support succession planning and sustainability.

The Infection Prevention and Control Board Assurance Framework (BAF) has been updated twice since December 2021, with a further 22 Key Lines of Enquiry (KLoEs). The BAF has been reviewed, and information and reports embedded within the self-assessment. The BAF self-assessments and subsequent updates have been shared with Trust and both NHS England & Improvement (NHSE & I) IPC leads, and Care Quality Commission (CQC) as detailed in previous Trust board 6-month IPC reports, all BAF actions are now completed and closed.

Purpose of the report

The aim of this report is to provide the Trust Board with assurance there is a robust, effective and proactive infection prevention and control programme in place, that demonstrates compliance with the Health and Social Care Act 2008 and to assure the board that all IPC measures taken are in line with government COVID-19 IPC guidance.

In addition the report provides updates on:

- Information, quality improvement learning and actions for compliance in regard to Covid-19 outbreaks and nosocomial Covid-19
- Podiatry decontamination update
- Monkeypox infection

Analysis of the issue

1. COVID-19 pandemic

1.1 The Covid-19 pandemic has been downgraded from level 4 to level 3. Management of patients with suspected or known Covid-19 continues both nationally and locally.

1.2 National guidelines and communications issued continue to be logged through the Trust Incident Control Centre and or Clinical Reference Group. Action cards for staff guidance are updated to ensure we have responded in an evidence-based way to maintain the safety of patients, staff, volunteers and contractors.

1.3 The UK Health Security Agency (UKHSA) updated its UK IPC guidance in May 2022 with new Covid-19 pathogen specific advice for health and care professionals aligned with the National Infection Prevention and Control Manual (NIPCM) for England. This applies to all NHS settings or settings where NHS services are delivered. It is acknowledged that organisations will require a period of transition to make changes and adapt operating procedures given local variation in infection levels and risk assessment of settings including ventilation, spacing and mask wearing.

1.4 To support this transition a 'living with Covid-19' risk assessment tool was adapted organisations local risk assessment to support local decision-making regarding mask use and spacing as part of the rest and rebuild programme. This helped the trust to transition back to pre-pandemic visiting and introduce safe visiting guidance. We also introduced a new triage and screening template on systmOne and have moved from three (low, medium, high) Covid-19 patient pathways to respiratory and non-respiratory pathways to guide patient placement, IPC precautions and Personal Protective Equipment (PPE) for contact.

1.5 Lateral flow testing for all staff within LPT continues to be supported and has been successful in identifying a number of staff who had a positive result despite being asymptomatic.

1.6 A task and finish group with a pilot test was set up to introduce Lateral Flow Device (LFD) for patient testing in place of PCR testing. This is supported in the national guidance. As an LFD is considered a medical device, a point of care testing policy and competencies for staff has been developed to support the process and governance requirements.

1.7 Between 1st April 2021 and 31st January 2022, LPT recorded 18 COVID -19 outbreaks, including incidents that occurred in non- clinical areas affecting staff only. 8 of the outbreaks occurred in Community Health Services and 10 occurred in Directorates of Mental Health, Families and Young People and Learning Disabilities Services.

1.8 <u>COVID-19 figures from 1st April 2021 – 31st January 2022:</u>

Total number of COVID-19 patient cases = 148

- Total number of COVID-19 cases 0-2 days = 13
- Total number of COVID-19 cases 3-7 days = 20
- Total number of COVID-19 probable nosocomial cases = 18
- Total number of COVID-19 definite nosocomial cases = 97

1.9 33 of the COVID-19 cases were attributed to community onset, picked up by screening. The remaining 115 cases are nosocomial.

1.10 Total number of COVID-19 staff cases = 996. Not all staff cases have been associated with outbreaks within the inpatient or community services. However, the impact on the workforce and the management of patients is reflected in these figures.

1.11 Learning identified as part of the outbreak reviews (included in the second aggregated review appendix 1) a further learning board included:

- Mask wearing by patients not documented, compliance or offer
- Testing of symptomatic patients delayed
- Extremely hard for some client groups to comply to isolation i.e., dementia patients documented evidence of this very good
- Social distancing between patients often difficult to achieve but staff have tried and documented
- Equipment not dedicated to positive patients only when could have been
- Storage in ward areas often limited meaning some cross contamination may have occurred
- BBE breaches continue despite large amount of education around topic – further training and Hand Hygiene audits continue
- Outbreaks have sometimes identified broken equipment e.g., dish washer, macerator that have been reported
- Patient swabbing generally good but often delays in receiving or reporting results
- Access to lab results - common delay
- Large amounts of asymptomatic cases.
- Facilities and domestics responded quickly when asked for deep cleans and enhanced cleaning to outbreak area
- Lack of therapy staff attendance at outbreak meetings
- Staff break areas often shared between areas which can lead to cross contamination
- LPT has a large number of old buildings not ideal for up-to-date IPC recommendations
- Some equipment on ward leading to cross contamination - continue to work with therapist to help minimise risk.
- Care plan usage for positive patients very poorly used

Overall outbreak meetings have been very positively received and support the management in a difficult period, often result with positive outcome to support the ward area.

2. Decontamination

2.1 During a review of the risk register, it was identified within Community Health Services that the risk regarding decontamination for Podiatry services, had not been recently reviewed. Decontamination compliance was audited in 2016 and then the actions had not been progressed. This was reported as a Serious Incident (SI), with an investigation carried out. The full report was completed in May 2022.

2.2 The scope of the SI was to look at the processes, audits and governance for podiatry held autoclave and washer disinfector machines servicing regimes and statutory pressure system testing. The investigation process reviewed the potential impact to patients and staff from a patient safety and quality perspective and to identify contributory factors and learning to ensure robust oversight of servicing, testing and auditing.

2.3 A number of recommendations and actions have been completed to rectify this position and a full and concise report submitted to Directorate Governance groups and Executive Directors and Trust Board members. These actions are monitored and updated by the service, escalations to CHS DMT

and exception reporting through the Quality Assurance Forum and Trust Board meetings. A number of actions to address the gaps in assurance were undertaken, these included:

- Task and finish group with weekly meetings set up and led by the Director of the Service
- Equipment service history reviewed and services undertaken
- Single use equipment used where decontamination was halted
- Audits carried out to identify any risks associated with the delivery of podiatry services
- An authorised Engineer for Decontamination was appointed, and a review was undertaken of the processes for decontamination used in podiatry services
- Decontamination group with quarterly meetings set up
- Decontamination policy and terms of reference under review (completion date Aug22)

3. Monkey pox (MPX)

3.1 Monkeypox is a rare disease that is caused by the monkeypox virus. Monkeypox is most commonly seen in central and west Africa but there has been a recent increase in cases in the UK as well as other parts of the world where it has not been seen before.

3.2 Monkeypox usually causes a mild illness that resolves without treatment and most people recover within a few weeks. However, severe illness can occur in some people. It is possible that young children, pregnant women and immunocompromised people are more at risk of becoming severely unwell than others.

3.3 Infection mainly spreads between people through direct (skin to skin) contact, including sexual contact, or close contact via particles containing the monkeypox virus. Infection can also be spread via contaminated objects such as linen and soft furnishings. The chance of catching the infection increases when there is close contact with an infected person who has monkeypox symptoms.

3.4 Monkeypox infection usually starts with symptoms such as fever, headache, muscle aches, backache, chills or exhaustion. This is followed by a rash a few days later that may start on the face, groin or hands, before spreading to the rest of the body. It starts as raised spots, which turn into small blisters filled with fluid (lesions). These blisters eventually form scabs which later fall off.

3.5 An individual with monkeypox is considered infectious from when their symptoms start, until their lesions have scabbed over, all the scabs have fallen off and a fresh layer of skin has formed underneath. This may take several weeks.

3.6 A number of meetings and actions have occurred over the last few weeks since the emergence of monkeypox as an infection in the UK. The following information outlines updates as of 20 June 2022

3.7 LPT response

- Staff communications sent out as updates received
- Action log commenced to support governance process and channel appropriate information
- Action card developed for community/inpatient staff as guidance for actions to be taken if a suspected case presents
- Action card developed for attendees at hospitals and healthcare
- Domestic staff identified for FFP3 training and is currently being provided by LPT to support UHL capacity

3.8 Midlands region meeting (East and West)

- Nationally cases up to 1400 with approximately 40 cases within East and West Midlands Region
- Most patients self-referring, identified as infectious prior to the rash developing which manages symptoms earlier and prevents cross contamination
- Majority of patients within the London or Southeast region
- Majority of those affected are men, with some women now testing positive.
- Patients mainly well and able to isolate at home
- A weekly update provided from UHSHA
- Consideration given to rename the infection to remove stigma
- Minimal association of mortality at the present time with the infection

4. Seasonal Flu vaccination programme – updated with figures from 22 March 2022

4.1 LPT is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine.

4.2 The flu vaccination programme runs between October and February every year. Last year the flu vaccination programme ran alongside the Covid-19 vaccination and booster programme.

4.3 The figures below identify the final position of the Trust for the uptake of the staff flu vaccine Winter 2021 / 2022

		Accurate to 22 March 2022	
		Influenza	
All staff	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Total	7393	4421	**59.8%**
Of which LPT staff	*6768*	*4082*	*60.3%*
Of which Workforce Bureau staff	*625*	*339*	*54.2%*
Staff with direct patient contact	5839	3440	**58.9%**
Of which LPT staff	*5229*	*3101*	*59.3%*
Of which Workforce Bureau staff	*610*	*339*	*55.6%*
Staff without direct patient contact	1554	981	**63.1%**
Of which LPT staff	*1539*	*975*	*63.5%*
Of which Workforce Bureau staff	*15*	*6*	*40%*

4.4 The figures for the uptake of the vaccine have been broken down into staff groups which supports further analysis and communication actions.

		Influenza	
Staff with direct patient contact by staff group (inc WFB) As reported to Public Health England each month	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Doctors	216	141	65.3%
Qualified Nurses, midwives and health visitors	2098	1362	64.9%
All other professionally qualified clinical staff	948	648	68.4%
Support to Clinical Staff	2320	1162	50.1%
Staff with direct patient contact	**5582**	**3313**	**59.4%**

4.5 The national average percentage seasonal influenza vaccine uptake for frontline healthcare workers – all NHS England Trusts 2021 to 2021 was 60.5%.

4.6 The seasonal flu vaccine for staff has been delivered using a multi-pronged approach to support flexibility and access opportunities for staff. The roving vaccinator team has predominantly delivered the staff flu vaccination programme. These clinics were at delivered in clinical settings and non-clinal environments to maximise uptake and opportunity. This programme of delivery was supported by peer vaccinators. Nationally there was a requirement to move to National Immunisation Vaccination System (NIVS) as the recording process which does not have a booking element, so clinics were all 'walk-in'. The opportunity to have the flu vaccination and the Covid booster at the same time has also been provided through the LPT and UHL Hospital Hubs.

4.7 The table below outlines the FHCW uptake by directorate teams up the 22 March 2022.

By Directorate

		Influenza	
Directorate	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Bank	1077	491	45.6%
CHS	1713	1149	67.1%
Enabling Services	581	390	67.1%
FYPC.LD	1572	993	63.2%
Hosted Services	220	131	59.5%
Mental Health Services	1605	928	57.8%
Workforce Bureau	625	339	54.2%
TOTAL	**7393**	**4421**	**59.8%**

4.8 Trust uptake data is further analysed including high and low uptake teams, teams with higher staff numbers with low uptake with a greater potential to improve/impact overall Trust performance.

4.9 Reasons for higher vaccination uptake triangulated with national data include key influencers within teams, committed leadership to the flu programme, flexibility and availability of flu clinics across LPT sites and a strong roving and peer vaccinator team.

4.10 Analysis of the reasons for not having the flu vaccine reported by staff are: too many vaccines in the previous 12 months (many staff have had x3 COVID vaccinations), low levels of circulating flu in the community and therefore not seen as a personal risk, lack of availability of a vegetarian/ vegan flu vaccine, concerns about allergies and therefore reluctance to have another vaccine and that flu is seen as having more serious consequences for older people and this is reflected in the age correlation of the flu vaccine uptake (lowest in the age group 18 – 30 and highest in the 65+ age group).

5. Reporting and monitoring of HCAI Infections

5.1 There are four infections that are mandatory for reporting purposes:

- Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections.
- Clostridioides difficile infection (previously known as Clostridium difficile)
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections.
- Gram Negative bloodstream infections (GNBSI)

5.2 MRSA Blood stream infection rates

The national trajectory is set at zero. The Trust performance for MRSA bacteraemia from April 2021 to March 2022 is zero.

5.3 Clostridium difficile infection (CDI) rates

The agreed trajectory for 2021/22 was 12 and is set internally by the Clinical Commissioning Group (CCG) (identified as EIA toxin positive CDI). There have been 11 cases of health care associated infection of CDI between April 2021 and March 2022. This slight increase reflects the national picture

- July 2021 – St Lukes, Ward 3
- September 2021 – Evington Centre, Beechwood Ward
  September 2021– Loughborough Hospital, Swithland Ward
- October2021 – Melton Hospital, Dalgleish Ward
- December 2021 – St Lukes, Ward 3
- December 2021 – Hinckley & Bosworth, North Ward
- January 2022 – Hinckley & Bosworth, East Ward
- February 2022 – Evington Centre, Clarendon Ward
- February 2022 – Evington Centre, Clarendon Ward
- February 2022 – Bennion Centre, Langley Ward
- March 2022 – Loughborough Hospital, Swithland Ward

5.4 All episodes of MRSA bacteraemia and CDI are identified and are subject to a Root Cause Analysis (RCA) investigation. All action plans developed as part of this process are presented to the Trust IPC meeting which supports the sign off of completed actions and an opportunity to share learning. Delayed sampling was identified as one of the learning points, and the need to consider infections other than Covid-19. Learning boards continue to be developed to share the findings across the directorates

5.5 **MSSA Blood stream infection rates**

There is no identified Trust trajectory for MSSA, with national requirements focused on acute trust services only. However, the monthly data for this infection rate is submitted to the Clinical Quality Reporting Group (CQRG) as part of the quality schedule, this supports the overview of the infection rates and the potential of an increase which may need further review and investigation

5.6 **Gram Negative Blood Stream Infection (GNBSI) rates**

In 2017 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Furthermore, the NHS Long Term Plan supports a 50% reduction in Gram-negative bloodstream infections (GNBSIs) by 2024/25. To help NHS systems achieve this, NHS England have developed a GNBSI reduction toolkit: a collection of guidance notes, actions and resources to support reducing GNBSI.

From April 2018 the Gram-Negative Bloodstream Infection rates include:

- E-Coli
- Klebsiella pneumonia
- Pseudomonas aeruginosa

5.7 There is no Trust trajectory for GNBSI, however monthly data for this infection rate is submitted to the Clinical Quality Report Group (CQRG) as part of the quality schedule reporting (Please note this captures E-Coli infection rates only).

5.8 Due to the pandemic a number of planned workstreams to look at improving the reduction in rates had halted, work is now underway to re-establish the working groups.

6. Ventilation

6.1 As part of the Facilities Management (FM) transformation planning and in light of the ventilation requirements/restrictions relating to COVID-19, the Trust appointed an Authorising Engineer (AE) for ventilation directly rather than using the shared service (hosted by University Hospitals of Leicester (UHL).

6.2 Following the appointment of the AE (V) in April 2021, they are working with the Trust ventilation group to progress arising issues, asset and compliance data checks, reviewing management processes and organisational governance arrangements.

6.3 An initial Ventilation Safety Group took place in May 2021 and has met subsequently at agreed intervals and the work plan continues to be developed.

6.4 A full ventilation audit is required, and a brief is being developed to obtain quotations. This action is under review by the Ventilation group and forms part of the work being undertaken by Turner &Townsend, Facilities Management in 7.5 below.

6.5 Information regarding the maintenance and management of systems from the shared service – hosted by UHL is being reviewed by the AE.

6.6 The AE provides advice and recommendations to individual queries raised and work has been undertaken at the Electro Convulsive Therapy (ECT) suite at the Bradgate Unit to ensure that services can continue in a COVID-19 safe way. Minor works completed and the area is compliant for ventilation, further works planned to increase space and upgrade ventilation services due to age/condition.

6.7 There are no emerging or immediate risks identified for action.

7. Water Management

7.1 The water safety group (WSG) continue to meet on a quarterly basis. The governance of the group is identified in the terms of reference, with an updated water safety group policy and water safety plan in place. The membership of the group has been independently confirmed by the Authorised Engineer for the trust (Hydrop).

7.2 Responsible person training identified within the water safety policy has been completed by the relevant staff employed within LPT and UHL. Further training is being undertaken by UHL estates staff and the water safety group have requested updates for each quarter.

7.3 Overall water compliance has steadily improved, but there remains a number of key areas the WSG continue to focus on with UHL required to rectify these issues. Those included with a level of improvement have been.

- work by the WSG and monthly Water meetings with UHL to improve the visibility of data, enabling the direction of tasks to be focused.
- Access to the system that holds the data for LPT has allowed scrutiny of Planned Preventative Maintenance (PPM) work, and therefore being able to identify. Overall data capture and compliance level is steadily improving.
- 99% of Trust water risk assessments are complete. Actions from the assessments are currently situated with UHL to complete.
- Coalville Community Hospital actions associated with the legionella outbreak have been completed with actions for the Bradgate Unit complete
- Monthly LPT/UHL Water Safety Action tracker meetings have created a report with clear responsibilities assigned to tasks, as they emerge, e.g., flushing, sampling, remedial actions to issues.

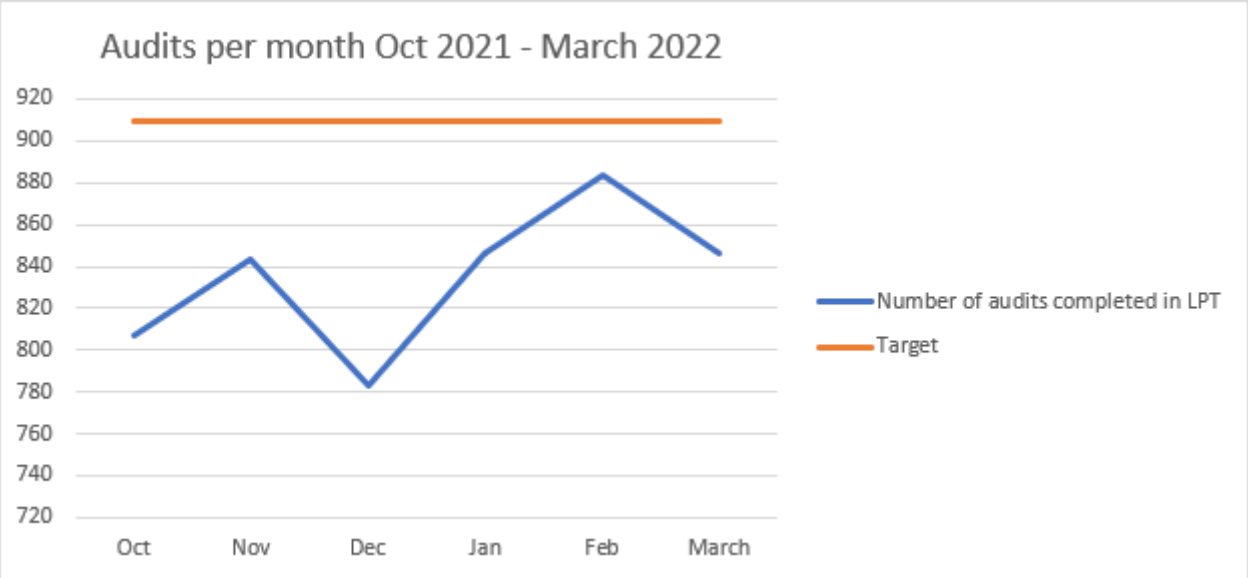
7.4 LPT has not undertaken water risk assessments previously. An action to survey all sites is near completion to support this further work. A task and finish group has been established and will focus on the prioritisation of the actions in the risk assessments, with an external company assigned to high-risk priorities.

8. Hand hygiene

8.1 The total number of audits required per month by all teams equates to 1516 audits per month to ensure more robust representative auditing. The aim for 2021/22 was to maintain the total number of audits at 909 audits (60%).

8.2 Q3 returned an average total of 811 hand hygiene audits and Q4 increased to an average of 859. Therefore, audits being completed remain under the expected average. A possible factor of this may be an issue which arose with inputting audits onto the hand hygiene app and the delay in reporting. Analysis and feedback have also shown that completion of audits has been impacted by changes to link IPC staff, staff working from home and staffing challenges affecting time to audit and input.

8.3 The graph indicates that on average, the number of hand hygiene audits being completed is considerably below the expected target of 909. Taking into consideration the possible factors outlined above, work continues to try to improve the number of audits being completed. For any newly identified IPC links, a team's meeting is offered to provide support on how to complete and input audits onto the hand hygiene app.



8.4 Hand hygiene audit reports are accessible via Staffnet. These are updated and uploaded onto Staffnet weekly. A draft monthly report has also been created by the information team which is going to the IPC Assurance Group for sign off in June 2022. Moving forwards, this report will be circulated monthly to the team leads. These reports will enable directorates to address any areas of concern.

8.5 There has been sustained compliance performance in terms of practice and results of the audits during Q3 & Q4, showing an average of 99%.

8.6 The Trust Infection Prevention and Control team continue with the in-patient clinical support visits that include a quality assurance review of hand hygiene practice and adherence to Personal Protective Equipment (PPE).

9. Cleaning

9.1 Cleaning audit outcomes are reported monthly through the Trust IPC Group. Exceptions are highlighted with mitigation and actions to remedy included in the report. Work continues to ensure clinical leaders are present at the time of the audits to confirm and challenge. Cleaning

services have been identified as an organisational risk which is reviewed at every IPC group meeting. Remedial actions have been put into place with a detailed improvement plan.

9.2 In line with the national recommendations, during Covid-19 peaks, two hourly touch point cleaning was implemented within inpatient areas. This process supported the reduction in outbreaks of infection, with specific reference to Covid-19. This process has been documented and audited to provide assurance. This action has since been reduced and is applicable in outbreak areas only.

9.3 A business case was developed, and a rapid response cleaning team was operationalised for supporting the introduction of a third clean in inpatient areas as well as a quick response to outbreak/cleaning requirements.

9.4 Cleaners rooms and equipment are audited monthly as part of the management audit undertaken by the Soft FM team.

9.5 The Trust has a twelve-month rolling deep clean programme in place and progress is monitored at the IPC Group.

9.6 A monthly facilities forum in place.

9.7 The National Standards for Healthcare Cleanliness 2021 has been implemented. Charters signed by the CEO and Chair are currently being produced for display in all areas of the Trust.

10. Antimicrobial stewardship

10.1 'Antimicrobial stewardship remains a vital tool in the fight against resistance and preserving the usefulness of antimicrobials so that they benefit patients who really need them.

10.2 The lead pharmacist for antimicrobial stewardship continues to oversee the maintenance of the actions and controls within the trust policy. This includes careful consideration of stock lists for inpatient wards, bi-annual audit, education and training and prescribing protocols.

10.3 Antimicrobial surveillance is a useful tool to monitor consumption. A sophisticated dataset has been developed to monitor trends in consumption across inpatient areas, with quarterly reports being fed into Medicines Management Committee and [pls insert the IPC meeting name].

10.4 The lead pharmacist for antimicrobial stewardship also continues to represent LPT in Leicestershire-wide groups.'

Proposal

This report outlines assurance from the Trust DIPaC demonstrating compliance with the Health and Social Care Act 2008. The report also highlights the impact of the COVID-19 pandemic to the business as usual IPC work programme and quality improvement in response to NHSE & I IPC visits.

Decision required

The board is asked to confirm a level of assurance that processes are in place to monitor and ensure compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to the as the Hygiene Code and NHS England IPC Board Assurance Framework to ensure that all IPC measures are taken in line with PHE Covid-19 guidance to ensure patient safety and care quality is maintained.

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Anne Scott – Executive Director of Nursing, AHP and Quality	
Paper authored by:	Amanda Hemsley – Lead Infection Prevention and Control Nurse	
Date submitted:	9.12.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Direct to trust board	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	6 monthly reports	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	5
Is the decision required consistent with LPT's risk appetite?	Yes	
False and misleading information (FOMI) considerations:	Yes	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		